

01-063

MENTAL HEALTH GENERALLY: ADMISSIONS AND DISPOSITIONS IN GENERAL — COMMUNITY MENTAL HEALTH SERVICES.

Emergency Medical Treatment Act does not preempt or conflict with statutes governing Commonwealth's involuntary commitment process for mentally ill adults in need of hospitalization. Act complements process by providing court with authority to place individual at any hospital with emergency room departments that execute Medicare provider agreements. Organizations affected by Emergency Medical Treatment Act and Virginia laws governing involuntary commitment process must comply with requirements of both laws; should develop annual written agreements with community services boards to reach satisfactory arrangements for provision of qualified examiners to perform evaluation services.

The Honorable Kenneth W. Stolle
Member, Senate of Virginia
June 28, 2001

You seek guidance regarding any conflicts between the Federal Emergency Medical Treatment and Active Labor Act¹ ("Emergency Medical Treatment Act") and §§ 37.1-67.01 and 37.1-67.1 of the *Code of Virginia*, regarding emergency custody and temporary detention orders.

Congress enacted the Emergency Medical Treatment Act in response to a growing concern about the provision of adequate medical services to individuals, particularly the indigent and the uninsured, who seek care from hospital emergency rooms. Congress was concerned that hospitals were dumping patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients' conditions stabilized.² The core purpose of the Emergency Medical Treatment Act is to get patients into the system who might otherwise go untreated and be left without a remedy, because traditional medical malpractice law affords no claim for failure to treat.³ Numerous cases and the legislative history of the Emergency Medical Treatment Act confirm that the sole purpose in enacting the Act was to deal with the problem of patients being turned away from emergency rooms for nonmedical reasons.⁴ The Emergency Medical Treatment Act thereby imposes a "limited duty on hospitals with emergency rooms to provide emergency care to all individuals who come there."⁵ Once the Emergency Medical Treatment Act has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians.⁶ The hospitals covered by the Emergency Medical Treatment Act are hospitals with emergency room departments that execute Medicare provider agreements with the Secretary of Health and Human Services.⁷

The Emergency Medical Treatment Act seeks to achieve the limited purpose of its enactment by requiring that the hospital provide limited stabilizing treatment to, or an appropriate transfer of, any patient that arrives with an emergency medical condition.⁸ The Act defines the term "to stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a [hospital] facility."⁹ The stabilization requirement is thus defined entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system. The stabilization requirement was intended to regulate

the hospital's care of the patient only in the immediate aftermath of the act of admitting the patient for emergency treatment and while it considered whether it would undertake longer-term full treatment or, instead, transfer the patient to a hospital that could and would undertake that treatment.

The Emergency Medical Treatment Act also requires that every hospital provide an appropriate screening for every individual who comes to its emergency department and determine whether the individual, in fact, has an emergency medical condition.¹⁰ In the absence of a statutory definition for the term "appropriate medical screening," it has been concluded that it should be defined as requiring participating hospitals to apply uniform screening procedures to all individuals coming to the emergency room of the hospital and requesting treatment.¹¹ The examination must determine "whether or not an emergency medical condition ... exists."¹² Under the Act, an "emergency medical condition" means

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual ... in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part[.]^[13]

If the hospital detects that an emergency medical condition exists, the Emergency Medical Treatment Act declares that

the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for the transfer of the individual to another medical facility^[14]

A hospital may not transfer an individual who has an emergency medical condition that has not been stabilized without a certification signed by a physician that, "based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual."^[15] The Act, thus, clearly provides that "the hospital's duty to stabilize the patient does not arise until the hospital first detects an emergency medical condition."¹⁶ Similarly, the transfer restrictions "apply only when an individual 'comes to the emergency room,' and after 'an appropriate medical screening examination,' 'the hospital determines that the individual has an emergency medical condition.'¹⁷

Sections 37.1-67.01 through 37.1-90 control the involuntary commitment process in Virginia for adults who are mentally ill and in need of hospitalization. Section 37.1-67.1 authorizes any magistrate, "upon the sworn petition of any responsible person or upon his own motion," to issue a temporary detention order ("TDO") "if it appears ... that the person is mentally ill and in need of hospitalization ... and the person is incapable of volunteering or unwilling to volunteer for treatment."¹⁸ Subject to several exceptions, the order may be issued "only after an in-person evaluation by an employee of the local

community services board or its designee."¹⁹ The detention period under a TDO is forty-eight hours,²⁰ after which a commitment hearing must be held or the person must be released.²¹ If it is determined at the commitment hearing that the person meets the commitment criteria specified in § 37.1-67.3, the judge issues an order of involuntary commitment.²²

Sections 37.1-67.01, 37.1-67.1 and 37.1-67.3 require community services board personnel to perform certain functions for the court related to the temporary detention and civil commitment process. Under § 37.1-67.01, a magistrate may, based on probable cause that a person is mentally ill and in need of hospitalization, and presents an imminent danger to himself or others or is substantially unable to care for himself, issue an emergency custody order requiring that the person be taken into custody and transported to a convenient location, which may include a hospital emergency room, to be evaluated by community services board staff to assess the person's need for hospitalization.²³ Custody of the person shall not exceed four hours.²⁴

The purpose for issuing an emergency custody order under § 37.1-67.01 is to obtain an assessment of the person's mental condition in order to advise the magistrate whether a TDO should be issued under § 37.1-67.1. An employee of the community services board or its designee must perform this in-person evaluation.²⁵ After receiving such evaluation, a magistrate may issue an order to temporarily detain the person pending the full commitment hearing under § 37.1-67.3.²⁶ The community services board personnel or designee determines the facility of temporary detention.²⁷ Under § 37.1-67.4, this institution may "provide emergency medical and psychiatric services within its capabilities when the institution [and not the community services board personnel] determines such services are in the best interests of the person within its care."

Prior to the commitment hearing, a psychiatrist or licensed psychologist, or if neither is available, a qualified mental health professional, who may be an employee of the community services board, but who must have no interest in the admission or treatment of the patient, must examine the person in private.²⁸ The examiner certifies to the court whether the person (i) is so seriously mentally ill as to be unable to care for himself, or (ii) presents an imminent danger to himself or others due to mental illness, and (iii) requires involuntary hospitalization or treatment.²⁹

The judge requires from the community services board a prescreening report stating whether the person is deemed so seriously mentally ill that he is substantially unable to care for himself, is an imminent danger to himself or others due to mental illness and in need of involuntary hospitalization or treatment, whether there is no less restrictive alternative to institutional confinement, and what the recommendations are for the person's care and treatment.³⁰ Should the judge determine that the person meets the commitment criteria, the community services board which serves the political subdivision in which the person was examined must designate the hospital or other facility in which to place the person.³¹ Prior to admission, however, the director of the hospital must examine the admission papers under § 37.1-68 to determine if they conform substantially with the law. Section 37.1-70 requires a physician on staff at the hospital to examine the person to determine if there is sufficient cause to believe that the person is mentally ill. If such examination reveals insufficient cause, the person must be returned to the locality in which the person resides or where the petition for commitment was initiated.³² Moreover, a court may not order examination of the person by a physician who has not voluntarily contracted to perform such services.³³ Although the community services board staff must designate the facility in which the person will be confined, the court may not require the hospital to admit the person over its objection; rather, admission to the hospital is accomplished in accordance with hospital policies and procedures.³⁴

Should the judge find that less restrictive alternatives to institutional confinement are available and that treatment can be monitored by the community services board or designated providers, the court may order outpatient commitment.³⁵ The community services board then recommends a specific course of treatment and programs for the provision of such treatment and monitors the person's compliance with such treatment as may be ordered by the court under § 37.1-67.3.

Although community services board employees must make recommendations for the person's placement, care and treatment, and examination and evaluation of a person may be performed on the premises of a hospital, such actions are considered recommendations to the court. The hospital director and admitting physician determine whether to admit a patient, and the treating professionals within the hospital, rather than the community services board employee or designee, prescribe treatment while the person is hospitalized. The community services board employee or designee monitors the prescribed treatment and reports to the court, as appropriate.

You first ask whether the Emergency Medical Treatment Act preempts or conflicts with §§ 37.1-67.01 and 37.1-67.1.

The Supremacy Clause of the Constitution of the United States provides that federal laws and treaties "shall be the supreme law of the land."³⁶ As you note in your opinion request, by virtue of this clause, any conflicting provision provided by such law or treaty would supersede state law.³⁷ The preemption of state law by federal law may occur by express statutory language or other clear indication that Congress intended to legislate exclusively in the area.³⁸ Even if Congress does not intend the enactment of a federal statutory scheme completely to preempt state law in the area, congressional enactments in the same field override state laws with which they conflict.³⁹

In adopting the Emergency Medical Treatment Act, Congress clearly has stated its intent not to preempt any state law, except where such law "directly conflicts with a requirement of [the Act]."⁴⁰ The Emergency Medical Treatment Act requires hospitals to provide individuals who come to the emergency department with "an appropriate medical screening examination."⁴¹ If the individual is diagnosed with an "emergency medical condition," the hospital must either stabilize the patient's condition or transfer the patient after fulfilling several statutory requirements.⁴² Federal regulations implementing the Emergency Medical Treatment Act define the term "emergency medical condition" to mean "[a] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, *psychiatric disturbances and/or ... substance abuse*)."⁴³ As noted, the purpose for issuing an emergency custody order under § 37.1-67.01 is to obtain an assessment of the person's mental condition in order to advise the magistrate whether a TDO should be issued under § 37.1-67.1.

The Emergency Medical Treatment Act and §§ 37.1-67.01 and 37.1-67.1, however, are not in conflict. Although the community services board staff must designate the facility in which the person will be confined, the court may not require a hospital to admit the person over its objection; rather, admission to a hospital is accomplished in accordance with hospital policies and procedures. Section 37.1-194 requires community services boards to provide "emergency services" within their respective jurisdictions; § 37.1-197(A)(12) requires that they develop annual written agreements with the courts specifying "what services will be provided to consumers." Such a contractual agreement may require the provision of emergency examinations upon request. Under certain circumstances, such a duty might give the court sufficient grounds to mandate performance by a community services board. The court may address these issues with the local community services boards, as well as with area psychiatrists and psychologists, to determine satisfactory arrangements for the provision of qualified examiners to perform

these services. The Emergency Medical Treatment Act will require hospitals with emergency room departments that execute Medicare provider agreements to conduct the examination of the person ordered by the court, regardless of whether the hospital has voluntarily agreed to perform such service. Consequently, I am of the opinion that the Emergency Medical Treatment Act does not preempt §§ 37.1-67.01 and 37.1-67.1.

Lastly, you ask whether §§ 37.1-67.01 and 37.1-67.1 may be amended to provide clarification to entities and organizations affected by those statutes and the Emergency Medical Treatment Act.

It is my opinion that the Emergency Medical Treatment Act complements §§ 37.1-67.01 and 37.1-67.1 by providing a court with the authority to place an individual at any hospital with emergency room departments that execute Medicare provider agreements. Consequently, I must also conclude that organizations affected by the Emergency Medical Treatment Act and §§ 37.1-67.01 and 37.1-67.1 must comply with the requirements of the federal and state statutes. It is, therefore, incumbent on such entities and organizations to develop annual written agreements with community services boards to reach satisfactory arrangements for the provision of qualified examiners to perform evaluation services.

¹42 U.S.C. § 1395dd (1994).

²See H.R. Rep. No. 99-241, pt. 1, at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 605 ("The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."); *Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993).

³*Brooks*, 996 F.2d at 710 (recognizing that, "[u]nder traditional state tort law, hospitals are under no legal duty to provide [emergency] care [to all]," and holding that purpose of Emergency Medical Treatment Act is simply to impose on hospitals legal duty to provide such emergency care); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (holding that purpose of Emergency Medical Treatment Act is "to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat").

⁴See, e.g., *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1189 (1st Cir. 1995) (stating that Congress enacted Emergency Medical Treatment Act because it was "concerned 'about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance'" (quoting H.R. Rep. No. 99-241, pt. 1, at 27, *reprinted in* 1986 U.S.C.C.A.N., *supra* note 2, at 605)); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995) (stating that Congress enacted Emergency Medical Treatment Act "in response to a growing concern about 'the provision of adequate emergency room medical services to individuals who seek care'" (quoting H.R. Rep. No. 99-241, pt. 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N., *supra*, at 726)); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) ("It is undisputed that the impetus to [the Emergency Medical Treatment Act] came from highly publicized incidents where hospital emergency rooms allegedly ... failed to provide a medical screening that would have been provided a paying patient, or transferred or discharged a patient without taking steps that would have been taken for a paying patient.").

⁵*Brooks v. Maryland General Hosp., Inc.*, 996 F.2d at 715.

⁶See 42 U.S.C. § 1395dd(d)(2)(A) (1994) (authorizing individual to recover damages for personal harm suffered as result of participating hospital's violation of Emergency Medical Treatment Act).

⁷See 42 U.S.C. § 1395cc (1994 & Supp. IV 1998); *see also* Brooks, 996 F.2d at 710.

⁸42 U.S.C. § 1395dd(b)(1) (1994); *see also* Vickers v. Nash General Hosp., Inc., 78 F.3d 139, 142 (4th Cir. 1996).

⁹42 U.S.C. § 1395dd(e)(3)(A) (1994).

¹⁰42 U.S.C. § 1395dd(a) (1994).

¹¹Brooks, 996 F.2d at 710-11.

¹²Section 1395dd(a).

¹³42 U.S.C. § 1395dd(e)(1)(A) (1994).

¹⁴Section 1395dd(b)(1).

¹⁵42 U.S.C. § 1395dd(c)(1)(A)(ii) (1994).

¹⁶Eberhardt v. City of Los Angeles, 62 F.3d at 1259.

¹⁷James v. Sunrise Hosp., 86 F.3d 885, 889 (9th Cir. 1996).

¹⁸The magistrate is to issue the TDO if the evidence indicates "that the person presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self." Va. Code Ann. § 37.1-67.1 (Michie Supp. 2000).

¹⁹Section 37.1-67.1.

²⁰*Id.* The person may be detained for a maximum of ninety-six hours if the detention period ends on a Saturday, Sunday, or legal holiday. Va. Code Ann. § 37.1-67.3 (Michie Supp. 2000).

²¹Section 37.1-67.3.

²²*Id.*

²³A law-enforcement officer also may take a person into custody based on probable cause that the person meets the criteria for emergency custody without prior authorization to obtain an assessment. Va. Code Ann. § 37.1-67.01 (Michie Supp. 2000).

²⁴Section 37.1-67.01.

²⁵Section 37.1-67.1.

²⁶A magistrate may issue a TDO without a prior in-person evaluation only if (i) the person has been personally examined by an employee of the community services board or

designee within the previous 72 hours or (ii) there is significant risk to the person or to others conducting the evaluation. Section 37.1-67.1.

²⁷This facility must have been approved to provide temporary detention services pursuant to regulations of the Board of Mental Health, Mental Retardation and Substance Abuse Services. Section 37.1-67.1.

²⁸Section 37.1-67.3 provides: "The examiner shall not be related by blood or marriage to the person, shall not be responsible for treating the person, shall have no financial interest in the admission or treatment of the person, shall have no investment interest in the hospital detaining or admitting the person . . . , and, except for employees of state hospitals and of the U.S. Department of Veterans Affairs, shall not be employed by such hospital. For purposes of this section, investment interest means the ownership or holding of an equity or debt security, including, but not limited to, shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments."

²⁹Section 37.1-67.3.

³⁰Section 37.1-67.3.

³¹Section 37.1-67.3.

³²Va. Code Ann. § 37.1-70 (Michie Repl. Vol. 1996).

³³*See* 1996 Op. Va. Att'y Gen. 166, 167.

³⁴1997 Op. Va. Att'y Gen. 141, 143.

³⁵Section 37.1-67.3.

³⁶U.S. Const. art. VI, cl. 2.

³⁷*Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 210-11 (1824); *see Savage v. Jones*, 225 U.S. 501, 533 (1912).

³⁸*See, e.g., Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977); *see Op. Va. Att'y Gen.*: 1984-1985 at 280, 282; 1973-1974 at 284, 285.

³⁹*See Jones v. Rath Packing Co.*, 430 U.S. at 525-26 (1977).

⁴⁰42 U.S.C. § 1395dd(f) (1994).

⁴¹Section 1395dd(a).

⁴²Section 1395dd(b)(1).

⁴³42 C.F.R. § 489.24(b) (2000) (emphasis added).

[Back to June Index](#)